COMMUNITY LIVING

COMMUNITY PLACEMENT OVERVIEW

When an individual's support team decides that residential supports are needed for an individual, the SC is responsible for making the referral and initiating the transition process. The referral process involves assuring that the individual is eligible to receive residential services through the Waiver, in most cases, and completing the necessary steps to gain funding, find a provider, and plan for the individual's move.

Community Placement means an individual is receiving residential services and funds from the Department of Mental Health (DMH), in a home or "facility" licensed by DMH. These services may be provided in the following types of environments:

- Family Living Arrangement (FLA)
- Independent Living Arrangement (ILA)
- Individualized Supported Living (ISL)
- Congregate Living Facility
  - Group Home
  - Residential Care Facility (RCF)
  - Intermediate Care Facility for Mentally Retarded (ICF-MR)
  - Skilled Nursing Facility (SNF)
  - Habilitation Centers

The concept of supporting persons with disabilities in the least restricted environment involves promoting choice and integration into the community. This includes prevention of unwanted/unnecessary admissions to facilities such as nursing homes or an ICF/MR facility. Support coordinators (formerly known as service coordinators) need to be involved in planning and monitoring of services to help ensure that community based services and /or natural supports are continuing to meet the individual's needs in order for them to be successful.

Best practices that should be considered by the support coordinator in regards to community placement are as follows:

- The placement should be in the best interest of the individual
- The provider should provide care and treatment consistent with the needs of the individual
- The support team should help maintain and encourage existing relationships to continue

Transition planning is essential for a successful move into any community living environment. Transition meetings should be scheduled no later than two weeks before the tentative move date in order for issues to be resolved prior to the actual move. The Transition Checklist is used as a guide to follow at the transition meeting.

Support Coordinator Roles/Responsibilities:

A. Meet with the individual/family to assure the Individual Service Plan addresses the needs/desires for placement, and necessary supports.

B. Complete Referral for Placement through the Utilization Review Process (refer to sample checklist later in this section).

C. The Regional Office director or designee approves the referral for placement, or for placement on the waitlist.

D. Document the support team's recommendation for residential services in the support plan

E. Assure that the consumer is Medicaid and Waiver eligible (in most cases)

F. Obtain funding by providing the necessary documentation of need to the UR Committee and, if recommended, obtain funding through the RO Director.

G. Assure that a transition meeting is held

H. Assure that the support team includes attendance and/or feedback from everyone involved in the individual's life

I. Monitor and follow up on outcomes and timelines

J. Facilitate communication between individual, family, and agency during transition period

If funding is approved:

A. The first step is to choose an eligible provider. If one has not already been identified, the SC should complete the **Individual Profile** form and forward to Regional Office Placement Coordinator for entry and publishing. This enters the individuals information into the Consumer Referral Database which notifies providers in the individual's chosen areas of his desire to interview providers

B. Complete eligibility check for Money follows the Person Demonstration [MFP](refer to program information on website) http://dss.mo.gov/mhd/general/pages/mfp.htm

Eligibility for MFP must meet all of the following criteria:

- In ICF/MR or Nursing Facility for at least 90 days
- In a certified and paid Medicaid bed
- Medicaid eligible

- Moving to community setting owned or rented by consumer/family member or residential setting no more than 4 individuals.

C. Work with individual/family to visit prospective service providers, meet potential roommates, and discuss relevant issues-what does the provider offer, what does the person need to have available to him/her. The guide "Finding a Residential Provider That is Right For You" is helpful for individuals and families. http://dmh.mo.gov/docs/opla/DDProviderGuide08.pdf
    - Develop information packet for prospective provider(s). This packet should include:
    - Individual Service Plan
    - IEP (if applicable)
    - Guardianship Information (if applicable)
    - Medical information
    - Financial information (benefits such as SSA or SSI, Medicaid, Medicare, Insurance, etc.)
    - Psychological evaluation (if available)
    - Any other pertinent information which may be helpful

Once a provider has been chosen:

A. Complete systems requirements:
    - If funding for placement will be provided under the Medicaid Waiver, complete the **MEDICAID WAIVER, PROVIDER, AND SERVICES CHOICE STATEMENT** and ICF-MR Level of Care forms. Refer to the Medicaid and Waivers section of this manual for details.
    - Assure that a transition meeting is held with the entire support team to include individual, family, guardian (if applicable), staff from the agency providing services and anyone else involved in the individual's life. See "Transition" later in this section.
    - Assure provider has necessary forms and information to begin providing needed support when the individual moves in.
    - Complete business office notification process. Each local Regional Office has a process they utilize to provide information to the business office regarding the move.
    - Complete any process needed for ancillary funds and personal spending.
    - Initiate update of information in CIMOR.
    - Complete any authorizations needed for services.

B. Assist individual/family with planning of move and follow-up to facilitate transition.

C. Assure that individual support planning is established or updated within 30 days of the move.